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Dr. Richard Kaul: 5 Points on Outpatient Surgery for Adolescent Spondylolisthesis

Written by Laura Miller | June 03, 2011

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Richard A. Kaul, MD, of New Jersey Spine and Rehabilitation, recently performed a minimally invasive surgical correction for a 16-year-old patient with spondylolisthesis. While the procedure wasn't different from those he performs on his older patients, the fusion process was quicker because of the patient's immature age. "When you work with the young spine, it fuses much more quickly than the adult spine," he says. "The bones heal faster for young patients."

Here, Dr. Kaul discusses five aspects on caring for his young patient with spondylolisthesis.

1. Identifying spondylolisthesis in young patients. Spondylolisthesis is usually reported among an older patient population. However, younger patients are increasingly experiencing repetitive stresses on their spinal column that could cause minor breaks or fractures. The stresses often occur as a result of competitive athletic activity, such as gymnastics, which was the case for Dr. Kaul's patient. "Within what she was doing, there must have been some instance where there was a force that caused a minor break in the pedicles and the break got bigger," he says. "Over time, there was slippage of the vertebrae which caused the spondylolisthesis."

In the past, physicians may not have been able to detect spondylolisthesis in young patients, but advances in diagnostic modalities have made it possible to spot the small fractures. "Now, we're regularly using CAT scans, MRIs and bone density tests to identify the fractures in the spinal column much more frequently," says Dr. Kaul.

2. Exhausting conservative treatment. The initial course of action for patients, especially young patients, diagnosed with spondylolisthesis is conservative treatment. Conservative treatment includes physical therapy, back strengthening activities and external supportive braces. If the spondylolisthesis is mild or moderate, these tools might be used for 3-6 months. "If the conservative treatment fails and there isn't a resolution of symptoms after six months to a year, surgery is often a solution," says Dr. Kaul.

3. Performing minimally invasive surgery. Dr. Kaul used fluoroscopic guidance to insert small instruments into the disc space. "We use the needle and guide wires to put in the dilators, and then we put a 9 millimeter sheath into the disc space on the left and the right," says Dr. Kaul. "It's through that sheath that we insert our instruments. The instruments take out the problem disc and prepare the disc space for fusion."

Once the problem disc is removed and the disc space has been prepared, the surgeon places a collapsed mesh cage down the portal. When the cage is in place, bone is inserted to expand the cage and restore the disc space. "Once the bone is inserted, we place pedicle screws to stabilize the back while the fusion is occurring," says Dr. Kaul. "When you put bone into the spine, you have to immobilize it for fusion. The cannulated pedicle screws allow us to put them in through a 2 millimeter incision."

The minimally invasive percutaneous approach is muscle sparing and has less bone loss and risk for infection. The procedure can be beneficial because it doesn't interrupt muscles, ligaments or bones surrounding the spinal canal.

4. Benefits of outpatient surgery. The minimally invasive surgery is an outpatient procedure, which means patients aren't exposed to overnight stays in hospitals. "If the patient stays in the hospital for a few days, they are exposed to more infections floating around," Dr. Kaul says. "With surgeries that are done on a same-day basis that issue doesn't come up."

5. Rehabilitation process. Patients undergo a postsurgical rehabilitation 6-8 weeks after surgery. When the inflammation has settled, the patient is able to begin strengthening exercises and isometrics. Usually, the rehabilitation program takes 6-8 weeks before completion. "When we did open procedures in the past, muscles were destroyed during the procedure, so there was more of a need to rehab them," says Dr. Kaul. "Now we aren't doing that, the requirement for postoperative rehabilitation isn't a big concern."

Learn more about Dr. Richard Kaul.

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Dr. Richard Kaul Launches Project Backbone to Provide Spine Care for Military Veterans

Written by Laura Miller | June 23, 2011

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Richard A. Kaul, MD, of New Jersey Spine and Rehabilitation, has begun Project Backbone, an initiative that will provide no cost back and spine care for veterans of the conflicts in Iraq and Afghanistan, according to a surgery center news release.

According to a military study, 56 percent of all fractures suffered during combat were spine related, and additional spinal injuries occurred from carrying heavy loads long distances. A 2001 study from the Army Science Board recommended soldiers not carry more than 50 pounds, yet they continue to carry up to twice that much for several miles.

Department of Defense's Clinical Practice Guidelines don't currently include protocol past conservative modalities, which means many veterans are denied surgical treatment. When treatment is approved, surgeons at many VA Hospitals employ traditional open procedures, which are associated with more muscle damage than the minimally invasive treatments Dr. Kaul performs.

Project Backbone offers veterans the opportunity to receive no cost consultations and no out-of-pocket expenses for surgical or pain management treatment. "These brave men and women put their lives on the line on a daily basis," said Dr. Kaul in the report. "The lease we can do to show our gratitude is ensure that they have access to the most effective care possible."

Learn more about Project Backbone.

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New Jersey Spine & Rehabilitation Begins Inter-Disciplinary Education Association

Richard Kaul, MD, of New Jersey Spine and Rehabilitation in Pompton Lakes, has announced the beginning of the Inter-Disciplinary Education Association, a program to bring physicians across specialties together to discuss collaborative diagnostics and modalities for treating patient pathologies.

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5 Tips for Spine Center Marketing & Business Development

New Jersey Spine and Rehabilitation in Pompton Lakes, a spine practice and surgery center, was founded in 2003 by Richard A. Kaul, MD. Dr. Kaul uses minimally invasive surgical techniques to treat patients with back pain and spinal disorders.

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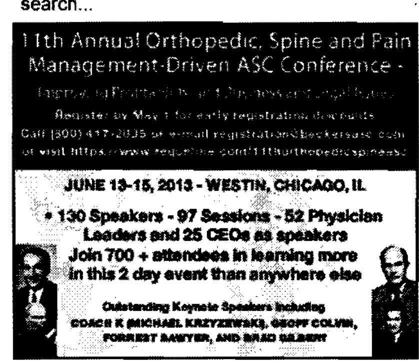

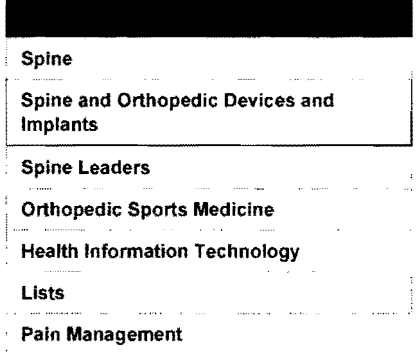

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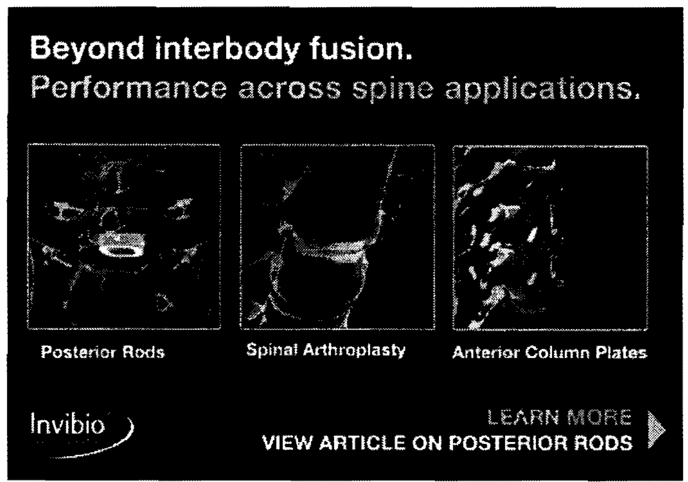

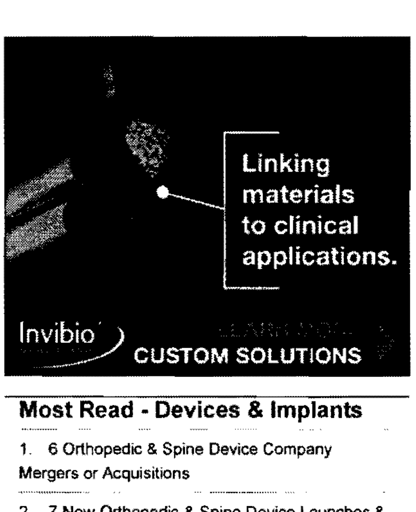

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Making the Case for the Endoscopic Approach to the Lumbosacral Spine: Q&A With Dr. Richard Kaul of New Jersey Spine & Rehabilitation

Written by Laura Miller | February 04, 2011

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Richard Kaul, MD, president of New Jersey Spine & Rehabilitation, has been performing percutaneous outpatient spinal fusions for the past five years and was the first surgeon in New Jersey to perform this procedure. He developed the procedure after training in Korea at Wooridul Hospital. Here, Dr. Kaul discusses the finer points of the procedure and how it benefits the healthcare industry.

Q: What is the technique for spine surgery that you perform?

Dr. Richard Kaul: The technique that I developed and have been using now for approximately six years, is a fluoroscopically guided video endoscopic approach to the lumbosacral spine. The techniques and technology that I had been using for disc decompressions formed the basis for the percutaneous interbody fusion. In 2004, the majority of lumbar fusions were being performed as open procedures, which invariably involved a significant degree of tissue destruction, blood loss and protracted postoperative rehabilitation. The development of the percutaneous approach enabled the performance of the same surgery in a minimally invasive fashion.

Q: How is the procedure carried out?

RK: The surgery is carried on a same day basis with the operative time ranging from two to four hours. A biportal fluoroscopically guided approach to the intervertebral disc is utilized. The use of an endoscope allows visualization of the intervertebral space and permits the surgical team to directly observe the decompression and endplate preparation. The use of a biportal approach allows an adequate disc space preparation bilaterally.

Q: What are the steps you take during surgery?

RK: Using fluoroscopic guidance, an 18 gauge 10 inch needle is inserted posterolaterally into the intervertebral disc. Using a guidewire, a blunt tip dilator is then advanced through the posterolateral compartments of the lumbar region into the disc space. Over the dilator, a 9 mm operating sheath is then placed. This procedure is carried in a bilateral manner.

One of the sheaths is used for placement of the video endoscope, while the other is used for insertion of the operating instruments. Using a set of specialized instruments a bilateral disc decompression and end plate preparation is performed. The endoscope allows direct video visualization of the surgical procedure while the fluoroscope provides essential radiological guidance. Once the disc space preparation has occurred the intervertebral space is partially filled with BMP and autograft from the iliac crest bone. The OptiMesh cage is then inserted into the space and filled with allograft bone. This technique allows the insertion of an intervertebral cage through a 9 mm portal and a significant restoration of vertebral height.

Q: What is the learning curve for surgeons who want to implement this type of procedure in their practice?

RK: The learning curve for this technique is quite steep, as it requires the acquisition of skills associated with radiological and video interpretation. To perform the procedure safely and effectively requires the surgeon to interpret 2 dimensional images in a 3 dimensional format. It is therefore important for surgeons looking to do this procedure to undertake the necessary hands on cadaver courses and spend time with practitioners experienced in this subspecialty of spine. Most spine fellowships do not incorporate the teaching of these skills into their program and the majority of surgeons will therefore have to obtain this knowledge once in clinical practice.

Q: Is the cost of the instrumentation a hindrance for surgeons who want to learn this procedure?

RK: The initial capital investment for the instrumentation is significant, as it requires the purchasing of endoscopes, specialized percutaneous instruments and fluoro video monitors. The other cost associated with ongoing education and time out of clinical practice. However, as spine surgery moves towards an increasingly less invasive approach surgeons will find more and more patients demanding the utilization of this technology, a factor which supports the economic argument for it's incorporation.

Q: Are there any advantages to performing this procedure as opposed to the traditional open procedure?

RK: Performing a percutaneous lumbar interbody fusion is associated with a significantly less blood loss, which in most cases amounts to no more than 50 cc. In addition, the postoperative recovery is quick and patients can be discharged on the same day. There is a lower infection rate,

due in part to the minimization of tissue destruction and patients require less, postoperative pain medications when compared to an open back procedure. There are also clear economic advantages due to the markedly reduced hospital stay.

Learn more about New Jersey Spine & Rehabilitation.

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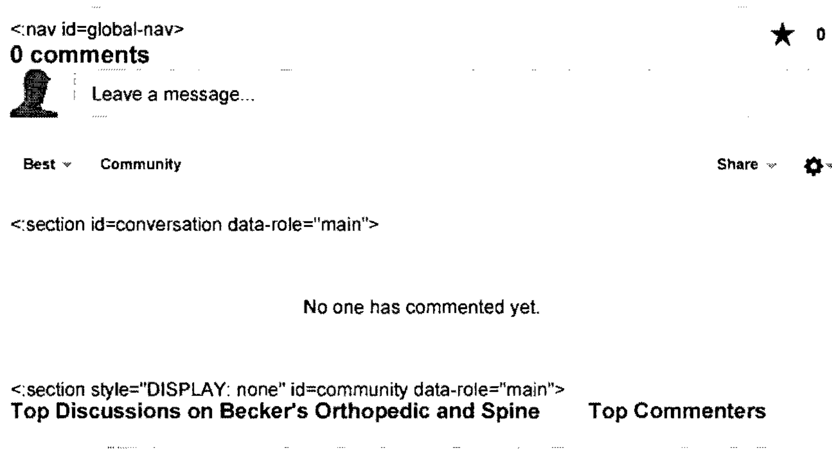

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Game Changers

Dr. Richard A. Kaul

Dr. Richard A. Kaul is the founder and President of The Spine Africa Project. Dr. Kaul, a Board Certified Minimally Invasive Spine Specialist by profession, founded this initiative after a trip to the Democratic Republic of Congo in 2008. This trip was prompted by a speech regarding the sexual violence against women in the Congo by Dr. Roger Luhiriri of The Panzi Hospital. Upon his visit, Dr. Kaul was confronted by the shocking lack of protocol for spinal injuries at the hospitals and clinics throughout the Congo. Despite the alarmingly high rate of spinal injuries due to the laborious working conditions, the injuries from the civil war that has permeated the Congo from Rwanda and the lack of pre-natal care, no protocols existed for spine injuries. Consequently, the life expectancy for someone afflicted with a spine injury is less than two years.

Dr. Kaul has long been lauded as a pioneer in Minimally Invasive Spine Surgeries and performed the first outpatient spinal fusion in New Jersey. Kaul is the Medical Director at NJSR Surgical Center, an outpatient Ambulatory Surgical Center, where he has been revolutionizing Minimally Invasive Spine Surgeries. Dr. Kaul has performed over 500 procedures, including many that no other physician has yet to attempt. His cases have been featured in several international newspapers, magazines and several national television appearances.

Dr. Kaul medical training is as extensive as it is impressive. Dually trained in both the United Kingdom and the United States, after his graduation from The Royal Free Hospital School of Medicine in London in 1988 he maintained positions as both the Surgical House Officer and Medical House Officer at both Lister Hospital and The Royal Free Hospital in the UK. After coming to America, Dr. Kaul held several Attending and Residency positions at hospitals including Columbus Hospital, St. Claire's Hospital and Hackensack University Medical Center. In 2007, Dr. Kaul began his private practice of New Jersey Spine and Rehabilitation. Throughout his career, Dr. Kaul has traveled across the world educating doctors on his methods and instituting several new protocols for hospitals internationally.

Dr. Kaul has also made international headlines for his philanthropic ventures, most notably, Project Backbone. This initiative provided no cost spine care and spine surgery to veterans of Iraq and Afghanistan and was coupled with a $500,000 donation to The Spine Foundation, a charity focused on financial assistance for those who can not afford their necessary spine treatments. This $500,000 donation was made toward The Spine Foundation's account for veterans.

To find out more about Dr. Kaul and The Spine Africa Project, please visit www.spineafricaproject.org

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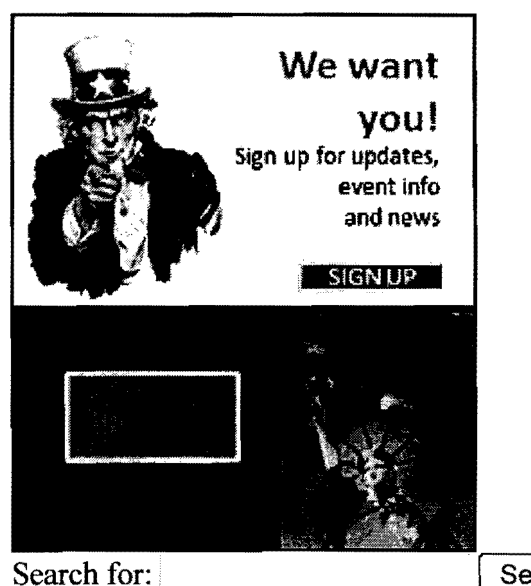

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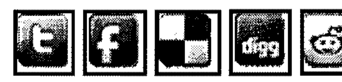

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Key Trends in Orthopedics and Spine in ASCs

Written by Abby Callard | October 29, 2011

At the 18th Annual Ambulatory Surgery Centers Conference in Chicago on Oct. 28, John Atwater, MD, McLean County Orthopedics, and Richard Kaul, MD, New Jersey Spine and Rehabilitation, participated in a panel discussion moderated by Jeff Leland, CEO, Blue Chip Surgical Center Partners, on key trends and ideas for orthopedics and spine in ASCs.

The past few years have seen an increase in spine procedures being done in the outpatient center.

"Very simply, the minimally invasive spine sector is growing," Dr. Kaul said. "I see this sector growing, and I see it growing within the outpatient community."

A decrease in blood loss and post-operative pain and improving technology are things that have facilitated that increase, Dr. Kaul said. However, learning to do these procedures in the outpatient setting requires more than just a cursory understanding.

"As the transition is being made from an inpatient to an outpatient, it's really important to identify people you can go spend time with," Dr. Kaul said. "Going to academic sources and cadaver courses are good, but it's better to go see it in a clinical practice."

Dr. Atwater did just that. He was not comfortable doing anterior cervical discectomies until he went and observed a surgeon who completed five within two and a half hours. Dr. Atwater also brought along his OR director, a nurse and first assistant to observe the procedure to ensure the entire staff was comfortable doing the procedure.

Drs. Kaul and Atwater also spoke about the ongoing issue of insurance reimbursements and both physicians agreed that the best way to justify the procedures is to continue to collect good clinical data. The key, Dr. Kaul said, is to create a dialog with the carrier and convince them that it makes more sense to go the procedures in an outpatient setting. Stressing that you can do the procedures safely, efficiently and for less money compared to a hospital setting are strong arguments.

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Spine Humanitarian Care: 3 Points on Spine Project Africa

Written by Laura Miller | April 09, 2012

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Richard Kaul, MD, president of New Jersey Spine & Rehabilitation in Pompton Lakes, recently returned to the Untied States after making his fourth medical mission trip to the Congo as part of the Spine Project Africa. Dr. Kaul established The Spine Project Africa to provide spine care for the underserved population in the Congo and promote education about spinal pathology among local physicians.

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Dr. Kaul and his surgical assistant, John Woods, were able to operate on 17 cases during this past trip, and saw another 150 patients in the clinic. "One thing that is very striking about the patients we see in the Congo is the degree of pathology because they don't have access to healthcare," says Dr. Kaul. "Their conditions have significantly deteriorated."

Expected pathology
Access to healthcare remains a huge issue in the Congo, so many patients suffer from very advanced spinal disorders and conditions that have been nearly eradicated in the western world — such as spinal tuberculosis. Many of the Congolese people have worked hard labor jobs for many years and developed injuries or deformities as a result.

The country also harbors refugees from the conflicts in Rwanda, and has been wracked with war and other conflicts for the past several years. Some patients present with traumatic injuries as a result of these conflicts.

"If I had to pick one part of the world where medical help is needed most, it would probably be the Congo," says Dr. Kaul. "They are at the bottom of United Nations rankings for their standard of living and they don't have any healthcare provisions. The physicians and medical students there don't have access to training in spinal pathology. That's why we feel the Congo is deserving of the efforts at this time."

Physician education
In addition to treating patients with complex spinal pathology, an important aspect of The Spine Project Africa is educating local healthcare providers so they can treat patients on their own. While in the Congo, specialists scrub into the procedures and work with Dr. Kaul and John Woods to learn their methods. Dr. Kaul also hopes to bring them to the United States for a fellowship at some point in the future.

"I really want to develop a three month fellowship program that would bring the physicians over to the United States to study," says Dr. Kaul. "That kind if educational program develops the connection between what we do here and what they do there. These guys handle orthopedic injuries but they have no training or expertise in diagnosing or treating spinal conditions or injury."

For now, the team makes due with conference calls every four weeks to discuss their cases.

Next Trip
Dr. Kaul and others participating in The Spine Project Africa will be taking their next trip to the Congo in September 2012. The trip will include surgeons, nurses and scrub technicians who have gone before — but the team is also looking to expand. The group hopes to raise $100,000 for transportation and materials associated with the trip.

"We would like to procure enough funding and have continuous funding that will allow us to pay for materials to be sent to the Congo on a regular basis," says Dr. Kaul. "In 2013, we are looking to raise closer to $500,000 so we can send a team out to the Congo ideally every three months."

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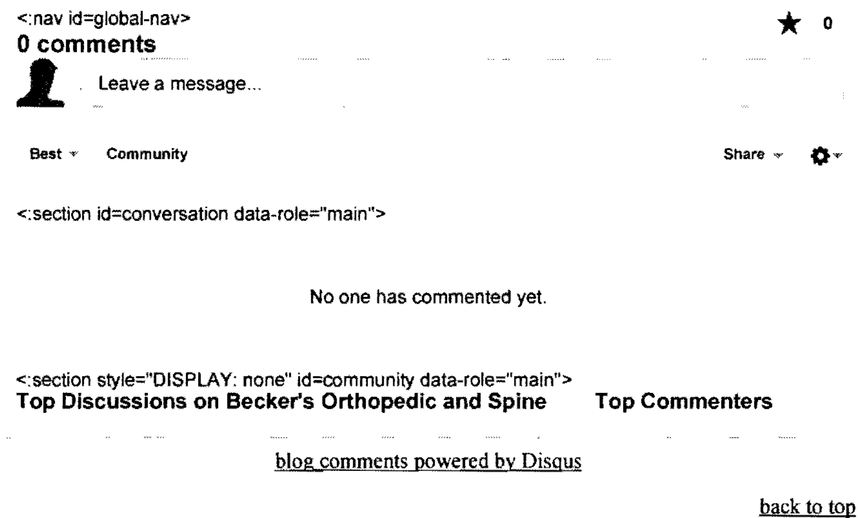

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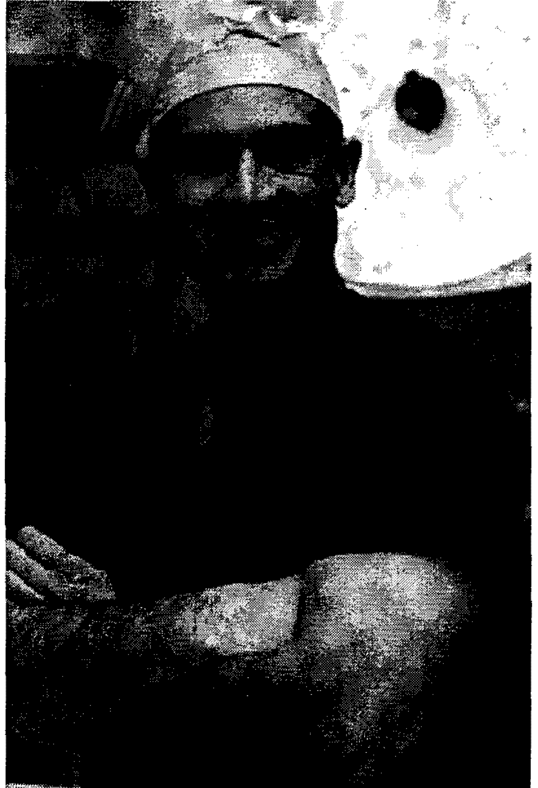
Improving lives through spinal surgery: The Spine Africa Project

Friday, 18 May 2012 11:35

The Spine Africa Project is a non-profit organisation that provides spinal surgery to under-served areas of Africa. Its current focus is the Eastern part of the Democratic Republic of Congo (DRC). Founder Richard Kaul, spinal specialist, New Jersey Spine and Rehabilitation, New Jersey, USA, talked to *Spinal News International* about the project.



Richard Kaul

Why did you set up The Spine Africa Project?

I founded the project in 2008 after travelling to the DRC with a friend, who was opening a school in the area. I was given the opportunity to tour a local clinic and what I saw on that trip was life altering. There were so many men, women, and children who were in great need of care, but there were no modalities to treat them. They were dying. This was the genesis of The Spine Africa Project.

The Spine Africa Project's website states that "Physical injuries, specifically spine related injuries, have begun to proliferate at a staggering rate" in the DRC. Why are such injuries increasing?

The proliferation of spinal injuries in the DRC can be attributed to several things. First and foremost, the harsh working conditions lack any kind of regulation or oversight.

Traditionally, males as young as 10 years old begin working in the mining sector. These are the same mines that have been the subject of the international conflict mining crisis [mining under conditions of armed conflict and human rights abuses]. These males typically work 16 hours days under militant control in incredibly unsafe conditions. Secondly, the Congolese women traditionally work in agriculture under equally arduous conditions and are often tasked with carrying 250 to 200lbs of goods strapped to their backs for seven to eight miles at a stretch. As you can imagine, the resulting spinal degeneration is widespread, quite significant, and chronically advanced. Finally, the Congolese children also present with high rates of severe

spinal conditions, such as spina bifida and spinal tuberculosis. This is mainly attributed to the lack of prenatal screening and preventative medicine.

Without help from your project, what would be the probable prognosis of a person with spinal injuries?

Sadly, without the intervention of The Spine Africa Project, those afflicted would have no treatment at all. Despite the high incidence of spinal injuries in that area of the world, physicians are not trained in the field of spinal medicine and their facilities are not equipped to perform spinal surgical procedures. The prognosis for untreated patients is a grim one. The complications associated with even mild spinal conditions are so debilitating that untreated patients often have a life expectancy of only 18 to 24 months following injury.

Why is education an important aim of The Spine Africa Project?

Educating and training the Congolese physicians is vital to this project due to the fact that we currently make only three to four trips to the DRC per year; however, these injuries occur every day and many patients do not survive long enough for us to treat them. It is imperative that we educate and train these physicians so that when they are presented with spinal injuries, they will have the knowledge and experience to confidently and effectively treat their patients. This allows our project to be a self-sustaining one rather than one that is solely reliant on our team.

How does the political situation in the DRC affect your project? Is it difficult to reach the people in need?

The political situation in the DRC is a complex one. In the capital city of Kinshasa, the Government has made strides to improve the infrastructure and the living conditions; however, 900 miles away in Bukavu, where The Spine Africa Project operates, there is little semblance of a functioning government.

The DRC comes at the absolute end of the list, at number 187, on the United Nations' ranking for living conditions and social indices. Things as commonplace as daily travel are complicated by a crumbling road system. The lack of a Government presence in this particular area has led to corruption and daily dangers.

Also, after patients are treated, there is a great challenge in contacting them and following up with them. The added absence of a functioning communication system within Bukavu means that once a patient leaves the clinic, you may never see him or her again.

How is the project being funded?

Currently, this project is funded by me and a small group of dedicated donors who contribute what they can. We have held fundraisers and have organised online donation campaigns. Thus far these have covered a small portion of the costs associated with the project. One of our goals for 2012 is to garner the support and/or partner with some of non-governmental organisations (NGOs) functioning within the Congo.

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World Wide Med: Saving Spines in the Congo

02/29/12

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A 2008 trip to the Democratic Republic of the Congo opened Dr. Richard Kaul's eyes to a serious, yet underrecognized health problem in the region: spinal injuries.

A friend who was opening a school in the Congo had invited him to visit in a general humanitarian way, to see whether there was anything he could do to help with her project.

However, "while I was there, I had the opportunity to visit two of the government medical clinics, and I observed that there was a high incidence of young males who had sustained spinal injuries in the mines," he said. The huge mining industry in the Congo is relatively unregulated and hazardous, and spinal fractures are extremely common. The injured young men were brought to the clinic, "but no one had any expertise or knowledge of how to treat them," he said. As a result, many men were sent back to their villages as quadriplegic or paraplegic, and many of them died within a few years from complications of immobility.

In addition, as Dr. Kaul notes on his website, women in this part of the Congo are at risk for spinal problems because they regularly travel several miles on foot over constantly changing terrain with upward of 200 pounds strapped to their upper backs. These packs can contain food, plants, water, or anything else they need to gather while most of the men (and male children as young as 7 years) are working in the mines. This exerts incredible amounts of pressure and force on both the cervical and lumbar spine.

"As you travel throughout the Congo you can see the majority of these women have a very evident slouch and are permanently hunched over," he said.

Dr. Kaul was inspired by this trip to found the Spine Africa Project, a nonprofit organization that has a twofold goal of providing treatment for those with spine injuries and educating the local physicians about spinal surgery.

Dr. Kaul graduated from London University in 1988 and finished medical school at the Royal Free Hospital School of Medicine. He came to the United States for postgraduate medical training at Montefiore Medical Center in New York.

What was your aim in starting the Spine Africa Project?

After my first visit, I started talking to people there about going back and trying to treat patients who were casualties of spinal injuries, and also teaching local doctors to diagnose and manage spinal pathology. A large part of what we are doing is educating the local doctors. It was shocking to me that there was a complete lack of understanding about spinal anatomy and pathology.

There is a small medical school attached to the clinic in which we operate. On our next trip, we will be spending about 25% of our time teaching and giving lectures. We bring the medical students and local doctors in for the surgeries and include them in the preop and postop care of these patients.

The local doctors scrub in on cases and operate with us, so we can demonstrate the technical aspects of surgery to them. We hope to get them to the point where they can handle the simple spinal decompression cases. And to have the project grow and continue, you have to have the local doctors brought on board in a very comprehensive way.

What types of surgeries are you performing?

We aren't at a point yet there where we can do complex surgeries. All of our surgeries are decompressions or posterolateral or posterior fusions. The interbody fusions and more complicated surgical operations have to wait until we have a reliable source of power. But one of our goals in the future is to be able to accommodate those cases as well.

What are the facilities like in the clinic?

The Panzi Clinic is fairly basic, but there is enough to allow us to carry out surgery. It's near the border with Rwanda. As in many parts of the Congo, there is sometimes an issue with running water and a reliable source of power. During our last trip, we were in the middle of a case when the power went down, and the anesthesiologist had to manually ventilate the patient. But that's part of the environment there.

There are small generators there, but in this case, both generators went out, and all we were able to do was apply pressure with gauze until the generator came back on, which took about 15-20 minutes. One of the elements of the project is raising funds to buy more generators for the hospital.

How long are your medical trips to the Congo, and how many physicians go along?

We go for about 2 weeks at a time and, in February 2012, we made our fourth trip. At the moment, the team consists of two surgeons. We use local nurses, technicians, and an anesthetist. We have had a lot of interest from doctors in the U.S. and in Europe. This year, we hope to have up to six or seven surgeons on the medical team.

What have you found most rewarding about the project so far?

The most rewarding thing to me has been the sense of gratitude that I feel from the patients that we see. The Congo is so socioeconomically deprived. When we go and start to see people, the fact that somebody is even interested in wanting to help them, there is such a sense of thankfulness that they have. To me, that has been very gratifying. That has been true even with patients that we aren't in a position to help right now, just the fact that we have seen them in the clinic and expressed interest in being able to help them in future, that has been one of the most rewarding elements of the project.

And, in a more tangible way, some of the patients we have treated have actually been able to get back into the workplace. The economic consequences of this are very significant. There are no safety nets for people there. If someone has a back injury and can't work, they can't go on disability; it doesn't exist.

By fixing their spinal issues, we allow them to get back into the workplace. These are the breadwinners for their families and for their villages, so the loss of that source of income can have catastrophic consequences for the family.

What are some other long-term goals for the project?

Finances need to be allocated for better water and electrical systems, as well as for communication systems. Without these things, any education will be in vain because these better practices can't be employed without basic necessities. Updated sterilization practices and updated presurgical protocols are imperative as well.

Another long-term goal is that we want to get a fellowship set up at our facility in the United States, so at some point over the next 2-3 years we can start to bring young doctors from the Congo over and get them some exposure to how things are done here so they can take that knowledge and expertise back to the Congo.

More information about the Spine Africa Project is available at spineafricaproject.org, and anyone who is interested in committing some of their time and services to help with the project can contact the organization by phone at 973-248-8818, ext. 204.

–Interview by Heidi Splete

This column, "World Wide Med," appears regularly in Internal Medicine News, a publication of Elsevier.

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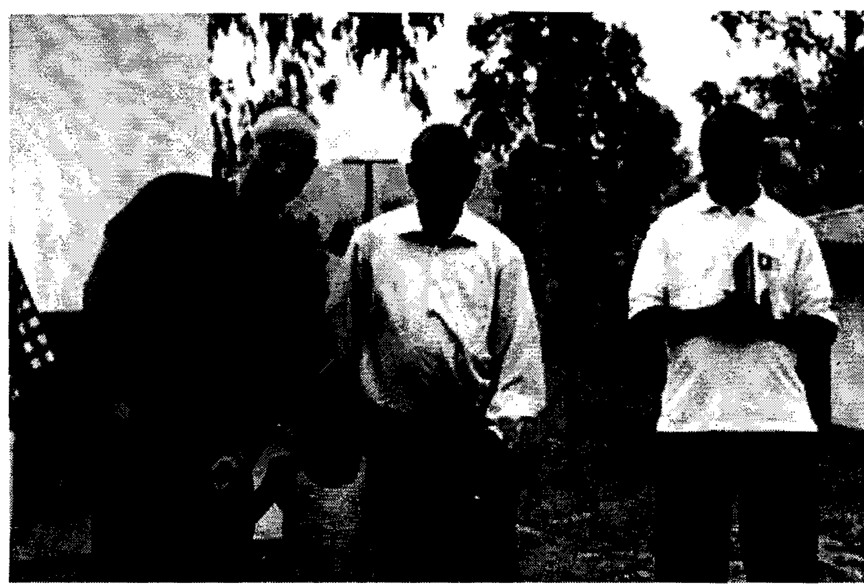

Dr. Richard Kaul founded the Spine Africa Project to help young men with spinal injuries return to work and provide for their families.

Dr. Richard Kaul is shown performing surgery.

Woman is shown carrying a heavy load of beans in the Democratic Republic of the Congo.

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Spine Africa Project

Posted on May 19, 2012

About the Spine Africa Project:

The mission of The Spine Africa Project focuses on three objectives: the treatment of those afflicted with spinal conditions, the education of local medical personnel, and social change. Each of these three factors contributes individually to what seems to be an exclusively medical epidemic.

The health issue would seem to be the most important. Everyday the incidence of spine injuries in the Congo increases, yet the advancement of spine care at the local and national hospitals remains stagnant. The Panzi Hospital, the hospital of focus for The Spine Africa Project, remains in a state of disrepair. The recent focus of The Panzi Hospital has been gynecological surgeries due to the disturbingly high incidences of sexual violence against women. However, sexual violence is not the only issue plaguing this impoverished country. Physical injuries, specifically spine related injuries have begun to proliferate at a staggering rate and have been afflicting men, women and children. Without proper protocols in place the life expectancy of someone injured has been determined to be less than two years. This shortened life expectancy does not simply affect the ill but, instead, the entire family.

The culture in the Congo has long been a communal one and all members, including children, work to provide financially for the family. Men, who are not enlisted into the militias, traditionally work in the multi-national owned mines. Also, children as young as 7 also begin working in these mines. Due to the lack of organized workforces and enforceable labor laws, most mine workers work up to 18 hours a day without proper safety equipment and only a small break for one meal. With the absence of the men, women are forced to assume many of the manual labor tasks such as agriculture and the transportation of goods. With the lack of labor laws the rate of pay stays abysmal with many making only about $1 per hour. Their meager wages are compiled and the entire family attempts to suffice on the combined wages despite the inordinately high cost of living.

For men, the long hours of heavy lifting and falling objects in the mine are a major source of spine

Follow

injuries. Proper equipment and policies are not used in these mines and the tremendous forces exerted to the body on a daily basis have exponentially increased the rate of disc degeneration and catastrophic injuries. For women, their risk is incredibly high due to the means in which they are transporting their goods. These women travel several miles on foot over constantly changing terrain with upward of 200lbs strapped to their upper backs. These packs can contain food, plants, water or any of the necessities that they are tasked to gather. This causes incredible amounts of pressure and force on both the cervical and lumbar spine and as you travel throughout the Congo you can see the majority of these women have a very evident slouch and are permanently hunched over. Children are also afflicted for several reasons including working conditions and the lack of pre-natal care. Obviously, the forces that are endured by a working child are detrimental due to the fact that their bones and joints are not fully developed and highly susceptible to injury. Children are often made to life heavy objects and work long hours whether they be in the mines or working in agriculture to help provide for the family. However, the most concerning issue for children is the lack in advancement in pre-natal care. Because of malnutrition of the mothers while pregnant, the prevalence of disease and the lack of pre-natal screening for deformities and illness. Tuberculosis is the major culprit of creating spinal deformities in children and because of the lack of immunization and screening, TB ravages the spines of children causing severe deformities.

This leads to the second part of The Spine Africa Project's mission: education. Most local doctors are trained in gynecological procedures as some general orthopedic procedures; however no training exists to combat the complicated and abundant spine injuries those in the surrounding villages are suffering. In many instances, injuries are worsened by improper treatments and the application of modalities that are in direct conflict with the proper techniques.

Our goal is to educate these doctors and implement proper techniques for treating and addressing these issues. Dr. Richard A. Kaul and his team will be making several trips to the Congo throughout the next few years and treating patients using the latest and most effective American technologies. However, the job is not completed after they depart, rather, that is where education becomes the most important factor. While in the Congo it will be the doctor's mission to teach these revolutionary procedures to the local doctors so that the work can continue even after Dr. Kaul and his team have departed.

However, this kind of education and awareness requires funding not only for the teaching but for the purchase of the necessary and up to date medical equipment required to perform these procedures safely. Sterilization and safety methods were a very great concern upon Dr. Kaul and Dr. Wood's most recent visit. It is evident that the facility had not been adequately maintained and sanitary practices were not even to par with the lowest of American standards. Updating the conditions will be a major factor to improving the standard of living in the Congo.

Check them out! We fully support their work in the DRC.

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Wednesday, March 27, 2013

Spine surgeon changing eastern Congo

By DANIEL GOLDBERG | Friday, January 27 2012 at 16:30

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Patrolling the Eastern Congo. Photo | FILE

Throughout the world, there are hundreds of charities dedicated to aiding different parts of Africa. Some truly help and others hope to solve the problem simply by raising money.

However, not many of those involved in the charity ever visit the area and truly "touch" those they aim to help. Well, Dr Richard Kaul and his Spine Africa Project (*www.spineafricaproject.com*) take it further than just "touching".

Dr Kaul actually travels multiple times per year to the eastern DRC to operate on those afflicted with debilitating and paralysing spine injuries, taking simply "touching" to actually "curing".

The cell phone or laptop computer that are so essential to our daily functioning may be among the most vicious contributors to the most flagrant abuses of human rights in the world.

Several hundreds of NGOs make an incredible profit from the sale and manufacturing of devices whose components are derived from the mines of the eastern Congo.

While traditionally mining has been a lucrative and respected trade, in the eastern Congo, this could not be more the opposite.

In terms of resources, the Congo is one of the richest countries in the world. Geological estimates indicate about $24 trillion in unmined resources, including gold and the "3 Ts", tin, tantulum and tungsten.

One or more of these "3 Ts" is found in almost all of our electronic devices and are essential to their functions. But have we ever stopped and asked where these minerals come from?

Most of us do not know, nor do we care. However, I am sure if we knew the truth, we would be appalled.

During the civil wars in Rwanda, violence spilled over into the DRC and violent militants created havoc on the once peaceful country.

One of their main targets was those who owned and operated the lucrative mines of the eastern DRC. They threatened the operators with physical violence, death and used extreme sexual violence against women as a form of psychological warfare.

Mining industry

Owners were forced to capitulate to the demands of these militants in fear of their lives and today, the mining industry is a faint and disturbing shadow of what it once was.

The conditions in these mines can only be described as “backbreaking”. Most of the work is usually reserved for men and children over the age of seven. Congruently, children make up 30 per cent of the workforce.

A work day is usually 14-18 hours of tenuous labour in which the miners are tasked to dig trenches, break through walls of sheer rock and carry hundreds of pounds of rocks out of the mines.

The mine owners only grant their employees one short break a day for a meal of little subsistence. All of these tasks are performed without the slightest intimation of the safety protocols we have become so accustomed to in the American mining sector.

In recent years, there have been efforts by the local governments to improve the working conditions, including the implementation of a minimum wage and the curtailing of extreme work hours. However, these are rarely enforced and if they were to be stringently enforced, the level of poverty would only proliferate.

The average daily wage for an adult male working in a mine is less than $2. Most of DRC is still communal families where each member works to earn a wage which is then pooled with all others in the family to provide the basic resources for survival.

If work hour regulations were enforced, this would reduce the mean income of a family, thus decreasing their ability to purchase these basic resources. So, despite the harsh working conditions, most Congolese are forced to object to the very regulations enacted to save their lives. In many instances, a debilitating injury will result in an entire family starving.

This is a result of the economic consequences an injury can impose, the number of family members remains the same, yet the unit is minus one wage. This one wage may be the difference between meagre survival and starvation.

In 2008, Dr Kaul, a successful spine surgeon pioneering innovative techniques in Minimally Invasive Spine Surgery, was enjoying a burgeoning practice in New Jersey.

Humanitarian capacity

That year, he attended a speech given by Dr Roger Luhiriri of Panzi Hospital (DRC) regarding the rampant sexual violence against women in eastern Congo.

Shocked and incensed by what he had heard, Dr Kaul immediately contacted friend and Congolese model Noella, to help him make travel arrangements to DRC so that he could use his medical knowledge to aid in a general humanitarian capacity.

A few short weeks later, Dr Kaul arrived in Bukavu. While in Bukavu, he was given the opportunity to tour several local clinics as well as meet with many of the local doctors.

While in the clinics, he noticed that many of the men, women and children were afflicted with spine injuries. When he inquired as to how the local doctors were treating these injuries, the answer changed his life forever, they simply were not treated.

He was informed that the doctors had neither the training nor the resources to treat these injuries. Those injured were discharged and returned to their villages.

Due to the neurological and physical impairments associated with a spine injury, their life expectancy was less than two years. From that very moment, The Spine Africa Project was born.

Foregoing the arduous and time consuming task of recruiting doctors and convincing them to travel to one of the most dangerous parts of the world, Dr Kaul and his co-surgeon John Woods simply decided that they themselves would travel multiple times per year to Panzi Hospital to perform life saving surgeries.

His still proliferating New Jersey practice would be put on hold during these sojourns. Since 2008, they have been making trips to the eastern DRC to carry out these admirable tasks.

The response from the local community, both medical and civilian, has been overwhelming. When news of Dr Kaul's and Woods' imminent arrival travels through the villages, countless families set out on a trek of hundreds of kilometres over several days, all in hopes to have their spine injuries examined. For their next trip, which begins February 3, they have planned over 25 surgeries in a mere 10 days.

This initiative is a tremendous undertaking, both in terms of time and resources. Prior to the last trip, over $20,000 of medical supplies was sent to Panzi Hospital.

The Spine Africa Project has employed several strategies in an effort to garner funds. One of the most important is raising public awareness of the Conflict Mineral Crisis and urging those companies who profit from the exports of the DRC to donate so that we may correct the health issues their quest for profits have caused.

-Daniel Goldberg is Director of Business Development, The Spine Africa Project

dgoldberg@spineafricaproject.org)

New Jersey Spine Surgeon Making A True Difference in Eastern Congo

Released: 4/24/2012 12:45 PM EDT
Source Newsroom: New Jersey Spine & Rehabilitation
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Newswise — Dr. Richard Kaul of New Jersey Spine and Rehabilitation recently began a medically focused charity known as The Spine Africa Project. This non-profit focuses on aiding the extremely high incidence of spine injuries in the Eastern Congo.

This organization was formed in 2008 after Dr. Kaul was invited to the Congo to attend the opening of a friends orphanage. While in Congo, Dr. Kaul was given the opportunity to tour the local clinics where he noticed that many patients within the clinic were suffering from life threatening spine injuries. When he inquired to the local doctors as to how these young men and women were being treated the answer he was given was staggering. They were not treated at all. Due to a lack of education and resources within Congo, provisions for spine surgeries did not exist. Even more disturbing was the fact that those with spine injuries were discharged and returned to their villages where there life expectancy was just a few months. At that very moment, The Spine Africa Project began.

Since 2008, Dr. Kaul has made 3-4 trips per year to Bukavu in the Eastern Congo to perform life saving spine surgeries for those injured. "Unlike most medical charities we do not have the funding of a major hospital or health organization nor a dedicated team of medical personnel." says Daniel Goldberg, Director of Charitable Resources. "As it stands now this project simply entails Dr. Kaul and his co-surgeon, John Woods, traveling to the Panzi Hospital to perform these procedures."

The occurrence of spinal injuries seems to have proliferated within the Congo for several reasons. For men, the main culprit seems to be the extremely dangerous and unregulated

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Description

New Jersey spine surgeon Dr. Richard Kaul has begun The Spine Africa project. An initiative which brings life saving spine surgeries to the Eastern Congo.

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conditions within the vast mines of Congo. This area of the world has been endowed with a tremendous amount of natural resources including tin, tantalum and tungsten. However, this endowment has made the Congo incredibly attractive to those looking to exploit the resources and lack of governance. These mines are the same ones that have been the subject of an international humanitarian crisis referred to as The Conflict Mining Crisis. The conditions in these mines are below even the lowest working standards. Men work in unsupported mining fields for 16 hours per day with no semblance of safety equipment or standards. Collapses within the mine or extreme injuries to the back and spine are all too common.

For women the contributing factors are just as great. Many women have been the victims of physical abuse and torture at the hands of the countless militias that occupy the Congo. These gruesome abuses often result in not only emotional but physical traumas as well.

For those lucky enough to escape the violence and enter into the workforce traditionally work in the agricultural field. Generally, this means spending long hours in a field hunched over picking various grains and beans. After this daily toiling has been completed the women are then charged with carrying these goods in 200lb satchels on their backs to market. In most cases, market is 5-6 miles away. Not surprisingly, the spinal degeneration this causes is so advanced that many women in their twenties have the spinal pathology of someone in their eighties. Many walk or stand with a noticeably curved hunch.

For children, the lack of pre-natal screenings and care has led to a high rate of complications that have been all but eradicated in the Western world including, Tuberculosis, Spina Bifida and HIV.

Despite the need for modalities to treat these conditions in the Congo, none yet exist. The Congo scores last out of 187 on the United Nations indexes of living conditions and has been plagued with internal struggle as well as violence at the hands of rebel groups from neighboring countries. These deficiencies have also influenced the medical education system

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within the country. Most physicians focus on general medical care or gynecological services and receive no education in the field of spine injuries.

"The most important element to this project may be the education of the local physicians," says founder and surgeon Dr. Richard Kaul. "We can not be on the ground 365 days per year but these injuries occur everyday. For this project to be a self-sustaining one the focus needs to be on education so the doctors are able to treat these injuries when we are not in Congo."

The conditions at Panzi Hospital have fallen into a state of disrepair. Within the hospital electricity and water are intermittent which makes for considerable safety and sterilization issues. "During one case, the electricity in the hospital cut off and we had to manually ventilate the patient for 20 minutes before the electricity was restored," recalls Dr. Kaul.

The teams next trip is planned for September 2012 where they will perform over 20 operations. "It is always incredible when we arrive at Panzi Hospital. Word of our arrival must spread and we usually have about 150 - 200 patients outside the clinic waiting to be seen. Many of whom have come from over 100 miles away through whatever means they were able to travel," says Kaul.

As of today this project is mostly self-funded with the help of a few grassroots fundraisers to help maintain costs. "One of the biggest factors is the cost associated with this program. Travel to Congo alone can be upward of $20,000," says Goldberg. "Also, we have to factor in the equipment necessary to perform these advanced procedures and how we can manage to procure them. Thankfully, we have gotten the material support of some medical device companies and some financial support from a close group of family and friends. However, the great majority of these trips are self-funded."

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